MCH/HEALTHTRACKS HEALTH HISTORY

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 1818 (Rev. 06-2002)

Program:				
Name:	Date of Birth:	Race:	Sex: ☐ M ☐ F	Telephone Number:
Address:	City:		State:	Zip Code:
Medicaid Number:	Social Security Number:	Name of Family Physician/Dentist:		
Information Provided By:	Other Agencies Involved:			

FAMILY/HOUSEHOLD

NAME LAST FIRST (MAIDEN)	SEX	MARITAL STATUS	RELATIONSHIP TO CHILD	DATE OF BIRTH	RACE

FAMILY HISTORY

	No	Yes	Maternal Side	Paternal Side		No	Yes	Maternal Side	Paternal Side
Cancer					Convulsions/Seizures				
Heart Disease					Mental Health (Depression, Suicide, Alcohol/Drug Use)				
Diabetes					Communicable Disease				
Allergies/Asthma					Other				

PAST HEALTH HISTORY

Prenatal History:			Approximately How Many Drinks Were Consumed During Pregnancy:
Condition of Infant at Birth:			
Premature ☐ No ☐ Yes-How many weeks? _____	Weight:	Height:	Birth Order in Family:
Mother's Age When Infant Was Born:	Is this child easy to parent? ☐ Yes ☐ No - See Comments		

HAS CHILD EVER HAD:	NO	YES	COMMENTS	HAS CHILD EVER HAD:	NO	YES	COMMENTS
Communicable Diseases (Chicken Pox, Measles, etc.)				Skin Disorder (Dermatitis, Eczema, Rashes)			
Convulsions/Seizures				Vision Disorders (Surgery, etc., Glasses, Eye Patch)			
Breathing Disorders/Asthma				Surgery/Accidents/Serious Injuries			
Allergies				Other			
Ear Infections							

IMMUNIZATION RECORD

	1	2	3	4	5		1	2	3	4	5
DTP/DTaP						Hep. B					
Hib						Varicella					
Polio						Td Booster					
MMR											
Hep. A											
Other											

Immunization Record Source:

OVER

DEVELOPMENTAL REVIEW - INFANT AND PRESCHOOL

Does the Child Have Trouble In Any Of The Following Areas **Now**:

☐ Sleeping	☐ Yes	☐ No	☐ Bedwetting	☐ Yes	☐ No	☐ Gaining Weight	☐ Yes	☐ No
☐ Speech Problems	☐ Yes	☐ No	☐ Frequently Ill	☐ Yes	☐ No	☐ Excessive Fears	☐ Yes	☐ No
☐ Temper Tantrums	☐ Yes	☐ No	☐ Appetite	☐ Yes	☐ No	☐ Nightmares	☐ Yes	☐ No

Are There Any Other Problems Not Mentioned Above?

SCHOOL AGE		CURRENT HEALTH OF CHILD	DATE LAST SEEN
What Grade Is The Child Presently In:	Name of School:	Doctor:	
Is The Child In Any Special Classes (Speech, Reading):		Eye Doctor:	
Does The Child Take Part In Other Activities (Sports, Music):		Dentist:	
Have There Been Any Changes In School Performance:		Specialist:	
Comments:		Counselor:	
		Medication:	
		Other:	

TEEN-AGE

Have Parents Talked To Child About: (Check All That Apply)

☐ Physical Changes ☐ Sex ☐ Menstruation ☐ Birth Control ☐ Wet Dreams ☐ Sexually Transmitted Disease (AIDS, Syphilis)

Do Parents Have Any Concern About: (Check All That Apply)

☐ Drinking ☐ School Performance ☐ Drugs ☐ Changing Attitude ☐ Choice of Friends

Is The Teen: (Check All That Apply)

☐ Dating ☐ Sexually Active ☐ Working ☐ Using Birth Control

☐ Would You Like The Teen To Be Referred To Family Planning _____

ANY CHANGES IN THE FAMILY: ☐ Date of Move

☐ Separation of Parent or Family Member/Divorce ☐ Gain of a New Family Member ☐ Recent Move ☐ Loss of Job

☐ Death of a Close Friend or Relative ☐ Does the Family Have Someone to Call for Help in Case of Family Problems? ☐ Yes ☐ No

SUMMARY:

Signature of Intake Worker:	Date:

HEALTH TRACKS ONLY

As parent/legal guardian/self. I hereby give my consent to release screening assessment information and to have him/her/myself undergo laboratory tests, examinations, and immunizations under the Health Tracks program for completion of the screening, diagnosis, and treatment and waive any legal action against any/all persons conducting the program. Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose this information will not affect participation in this program.

Signature:	Date:	Witness Signature:	Date: